



Office of Public Instruction  
Linda McCulloch, Superintendent  
PO Box 202501  
Helena, MT 59620-2501

# Individualized Education Program

Student Name	Initials	Birth Date	Age	Gender M F	Grade	Today's Date
District / School	Last Reevaluation					
	IEP Manager and Phone Number					
Parent(s)' Name	Parent(s)' Address				Home Phone	
	E-mail				Work Phone / Cell Phone	
<b>Optional Child Count Information:</b> Disability Category:			Race and Ethnicity:			

## STRENGTHS, EDUCATIONAL CONCERNS AND PREFERENCES/INTERESTS

### Strengths, Preferences and Interests - Etudent's Perspective

\_\_\_\_\_

\_\_\_\_\_

### Student Strengths

Parents: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

School Staff: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Educational Concerns

Parents: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

School Staff: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CONSIDERATION OF SPECIAL FACTORS

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| • Does the student's behavior impede his/her learning or that of others? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the student have communication needs?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the student require assistive technology devices or services?     | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has the student been determined to be "Limited English Proficient"?    | <input type="checkbox"/> | <input type="checkbox"/> |

**Any item above checked "Yes" must be addressed in the IEP.**

- |  | N/A                      | YES                      | NO                       |
|--|--------------------------|--------------------------|--------------------------|
| <b>For a student with blindness or visual impairment</b>   | <input type="checkbox"/> |                          |                          |
| • Does the student need training in orientation and mobility?  |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b><u>If "Yes" is checked</u></b> , training must be addressed in the IEP.   |                          |                          |                          |
| • Does the student need instruction in Braille or the use of Braille?  |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b><u>If "No" is checked</u></b> , describe in the notes why instruction in Braille or the use of Braille is not appropriate. This decision must be based on evaluation results. |                          |                          |                          |

Student Name: \_\_\_\_\_

IEP Date: \_\_\_\_\_

### TRANSITION SERVICES

For ALL students beginning with the IEP to be in effect when the child is 16 and updated annually thereafter.

**STUDENT'S DESIRED POST-SCHOOL ACTIVITIES:**

(In the areas of postsecondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living or community participation)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESULTS OF AGE-APPROPRIATE TRANSITION ASSESSMENTS:**

(  Results Attached)

**EDUCATION:** \_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT:** \_\_\_\_\_

\_\_\_\_\_

**TRAINING:** \_\_\_\_\_

\_\_\_\_\_

**INDEPENDENT LIVING SKILLS (if appropriate):** \_\_\_\_\_

\_\_\_\_\_

### MEASURABLE POSTSECONDARY GOALS

Measurable postsecondary goals are based on age-appropriate transition assessments related to training, education, employment, and, if appropriate, independent living skills. Clearly specify the desired level of achievement.

**Measurable Postsecondary Goal(s) – Education or Training:**

**Measurable Postsecondary Goal(s) – Employment:**

**Measurable Postsecondary Goal(s) – Independent Living Skills (if appropriate):**

### TRANSFER OF RIGHTS AT AGE OF MAJORITY

The student has been informed of his or her rights under IDEA that will transfer to the student on reaching the age of majority. The student must be informed at least one year before the student reaches age 18.

Date student was first informed of the transfer of rights: \_\_\_\_\_

Date student reaches the age of majority: \_\_\_\_\_

**Deleted box pertaining to Training; made the Education box pertain to both Education and Training**

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

- Describe below a coordinated set of activities designed within a results-oriented process to:
- focus on improving the academic and functional achievement of the student;
  - directly relate to the student's measurable postsecondary goals and the student's strengths, preferences and interests; and
  - promote movement from school to post-school settings and activities.

**Courses of study needed to assist the student in reaching her or his goal(s):**

Anticipated Graduation Date: \_\_\_\_\_ Credits earned to date: \_\_\_\_\_

Total number of credits required for graduation: \_\_\_\_\_

School Year	Credit	School Year	Credit
_____ / _____	___ / ____	_____ / _____	___ / ____
_____ / _____	___ / ____	_____ / _____	___ / ____
_____ / _____	___ / ____	_____ / _____	___ / ____
_____ / _____	___ / ____	_____ / _____	___ / ____
_____ / _____	___ / ____	_____ / _____	___ / ____
_____ / _____	___ / ____	_____ / _____	___ / ____
_____ / _____	___ / ____	_____ / _____	___ / ____
	TOTAL ___ / ____		TOTAL ___ / ____

TRANSITION SERVICE AREA	TRANSITION SERVICES NEEDED TO ASSIST THE STUDENT IN MEETING POSTSECONDARY GOALS (include timeline for achievement)	PERSON OR AGENCY RESPONSIBLE	ANNUAL GOAL # (if necessary)
INSTRUCTION	<input type="checkbox"/> Discussed and not needed		
EMPLOYMENT	<input type="checkbox"/> Discussed and not needed		
COMMUNITY EXPERIENCES	<input type="checkbox"/> Discussed and not needed		
POST-SCHOOL ADULT LIVING	<input type="checkbox"/> Discussed and not needed		
RELATED SERVICES	<input type="checkbox"/> Discussed and not needed		
DAILY LIVING SKILLS (IF APPROPRIATE)	<input type="checkbox"/> Discussed and not needed		
FUNCTIONAL VOCATIONAL ASSESSMENT	<input type="checkbox"/> Discussed and not needed		

Student Name: \_\_\_\_\_

IEP Date: \_\_\_\_\_

**OUTCOME MEASURES FOR 3,4,5, AND 6-YEAR-OLD CHILDREN**

The IEP team must address each of the three performance statements below. If this is an INITIAL IEP, rate the child’s present level of performance according to the measures on the left. If this is an ANNUAL IEP, rate the child’s performance according to the measures on the right.

**Do not complete this page if this is an INITIAL IEP for a 6-year-old student.**

**POSITIVE SOCIAL-EMOTIONAL SKILLS, INCLUDING SOCIAL RELATIONSHIPS**

**This child’s present level of performance:**

**Initial IEP (for 3, 4, or 5 year olds only)**

- Is comparable to same-aged peers
- Is NOT comparable to same-aged peers

**Annual IEP (for 3 through 6 year olds)**

- Maintained a level comparable to same-aged peers
- Reached a level comparable to same-aged peers
- Improved to a level nearer to same-aged peers, but did not reach that level
- Improved, but not sufficient to move nearer to a level comparable to same-aged peers
- Did not improve

**ACQUISITION AND USE OF KNOWLEDGE AND SKILLS, INCLUDING EARLY LANGUAGE, COMMUNICATION AND EARLY LITERACY**

**This child’s present level of performance:**

**Initial IEP (for 3, 4, or 5 year olds only)**

- Is comparable to same-aged peers
- Is NOT comparable to same-aged peers

**Annual IEP (for 3 through 6 year olds)**

- Maintained a level comparable to same-aged peers
- Reached a level comparable to same-aged peers
- Improved to a level nearer to same-aged peers, but did not reach that level
- Improved, but not sufficient to move nearer to a level comparable to same-aged peers
- Did not improve

**USE OF APPROPRIATE BEHAVIORS TO MEET INDIVIDUAL NEEDS**

**This child’s present level of performance:**

**Initial IEP (for 3, 4, or 5 year olds only)**

- Is comparable to same-aged peers
- Is NOT comparable to same-aged peers

**Annual IEP (for 3 through 6 year olds)**

- Maintained a level comparable to same-aged peers
- Reached a level comparable to same-aged peers
- Improved to a level nearer to same-aged peers, but did not reach that level
- Improved, but not sufficient to move nearer to a level comparable to same-aged peers
- Did not improve

**Indicate the assessment procedure(s) used to draw these conclusions:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Academic      | <input type="checkbox"/> Behavioral       | <input type="checkbox"/> Classroom-Based Assessment |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Developmental    | <input type="checkbox"/> Observations               |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Social/Emotional | <input type="checkbox"/> Other: (describe)          |

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

**PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE AND MEASURABLE ANNUAL GOALS**

**Special Education/Related Service Area:** \_\_\_\_\_

Describe the academic, developmental and functional strengths and needs of the student and how the disability affects involvement and progress in the regular curriculum or, for preschool children, involvement in appropriate activities. Test scores alone are insufficient.

**Present Levels of Academic Achievement and Functional Performance:**

Describe academic and functional goals to meet the student's identified needs and enable the student to be involved in and make progress in the regular education curriculum. Clearly specify the desired level of achievement.

**Measurable Annual Goal (# \_\_\_\_\_):**

Mark here if the Measurable Annual Goal will be part of an Extended School Year service:

<b>Date of Progress Report:</b>								
Goal not yet started								
Not expected to meet goal								
Expected to meet goal								
Met goal								

Describe academic and functional goals to meet the student's identified needs and enable the student to be involved in and make progress in the regular education curriculum. Clearly specify the desired level of achievement.

**Measurable Annual Goal (# \_\_\_\_\_):**

Mark here if the Measurable Annual Goal will be part of an Extended School Year service:

<b>Date of Progress Report:</b>								
Goal not yet started								
Not expected to meet goal								
Expected to meet goal								
Met goal								

When will progress reports on the measurable annual goal be provided to the parents?

quarterly  semester  other:

**deleted mid-term as an option for when the reports will be provided**

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

**PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE, MEASURABLE ANNUAL GOALS AND BENCHMARKS OR SHORT-TERM OBJECTIVES**

**Special Education/Related Service Area:** \_\_\_\_\_

Describe the academic, developmental and functional strengths and needs of the student and how the disability affects involvement and progress in the regular education curriculum or, for preschool-aged children, involvement in appropriate activities. Test scores alone are insufficient.

**Present Levels of Academic Achievement and Functional Performance:**

\_\_\_\_\_

Describe academic and functional goals to meet the student's identified needs and enable the student to be involved in and make progress in the regular education curriculum. Clearly specify the desired level of achievement.

**Measurable Annual Goal (# \_\_\_\_\_):**

\_\_\_\_\_

<b>Date of Progress Report:</b>								
Goal not yet started								
Not expected to meet goal								
Expected to meet goal								
Met goal								

**Benchmarks or Short-Term Objectives:**

(Mark  only if the benchmark or short-term objective will be part of an Extended School Year service.)

	<b>ESY</b>
	<input type="checkbox"/>

When will progress reports on the measurable annual goal be provided to the parents?  
 quarterly     semester     other: **deleted mid-term as an option for when the reports will be provided**

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

**SPECIAL EDUCATION AND RELATED SERVICES**

Special Education or Related Service Area	Hours per week in Special Education Setting	Special Education Hours per week in <b>Regular</b> Education Setting	Total hours per week	Dates of service (if different from annual IEP dates)
<b>Total Hours:</b>				

**PARTICIPATION IN THE **REGULAR** EDUCATION PROGRAM**

**Students ages 6 and above**

- Regular Class  
*(In the regular education class at least 80% or more of the day)*
- Part-time Special Education  
*(In the regular education class between 40% and 79% of the day)*
- Full-time Special Education  
*(In the regular education class less than 40% of the day)*
- Separate Day School *(public or private)*
- Residential Facility *(public or private)*
- Homebound/Hospital

**Students ages 3-5**

Early Childhood Setting means a program outside the child's home that includes at least 50% children without disabilities. Examples: Head Start, Kindergarten, Private preschool, group child care.

- Early Childhood Setting *(at least 80% of the time.)*
- Early Childhood Setting *(40% to 79% of the time)*
- Early Childhood Setting *(less than 40% of the time)*
- Special Education Setting - Separate Class *(less than 50% children without disabilities)*
- Separate Day School *(public or private day schools designed specifically for children with disabilities)*
- Residential Facility *(public or private)*
- Home *(public or private day schools designed specifically for children with disabilities)*
- Service provider location *(received all special education and related services from a service provider, and did not attend other program)*

**LEAST RESTRICTIVE ENVIRONMENT**

**A student with a disability shall not be removed from education in age-appropriate regular classrooms solely because of needed modifications in the regular education curriculum.**

- The educational placement is based on the student's IEP.  YES  NO
- The educational placement is as close as possible to the student's home.  YES  NO
- The educational placement is in the school that the student would attend if he or she did not have a disability.  YES  NO
- The IEP team considered any potential harmful effect of the educational placement on the student or on the quality of needed services.  YES  NO

**If "No" is checked,** explain why. \_\_\_\_\_

If the student's school day or week is shorter or longer than peers without disabilities, explain why. \_\_\_\_\_

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

### SUPPLEMENTARY AIDS AND SERVICES

Regular education classes, other education-related settings, and extracurricular and nonacademic settings, where accommodations/modifications are needed.

Specific accommodations, modifications, supplementary aids and services, assistive technology or other forms of support to enable children with disabilities to be educated with children without disabilities. Include program modifications or supports for teachers, related service providers, transportation providers and others working with this student.  None Needed

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PARTICIPATION IN STATE/DISTRICTWIDE ASSESSMENTS

The student will participate in the State/Districtwide assessments in the following manner: (Check one box for each test.)

**IOWA Tests (Grades 4, 8, 11)**  N/A

- Without accommodations
- With accommodation(s)
- Alternate Assessment Scale

**CRT Tests (Grades 3-8, 10)**  N/A

- Without accommodations
- With accommodation(s)
- CRT-Alternate\*

**Districtwide Tests**  N/A

- Without accommodations
- With accommodation(s)
- Alternate Assessment

Identify any test accommodations that must be provided for the student:

IOWA: \_\_\_\_\_

CRT: \_\_\_\_\_

Districtwide: \_\_\_\_\_

For any student who participates in an alternate assessment describe:

Why the child cannot participate in the regular assessment, and;

\_\_\_\_\_

Why the particular alternate assessment selected is appropriate for the child.

\_\_\_\_\_

\* The student may not participate in the CRT-Alternate unless the student's demonstrated cognitive abilities and adaptive behavior require substantial adjustments to the regular curriculum; learning objectives and expected outcomes focus on functional application, as shown by the IEP's goals/objectives; and the student requires direct and extensive instruction to acquire, maintain, regularize and transfer skills.

For students who participate in the CRT-Alternate, the student's IEP must contain benchmarks or short-term objectives.

### EXTENDED SCHOOL YEAR

- Extended School Year services **are necessary** for the student.
- Extended School Year services **are not necessary** for the student.
- Determination of need for Extended School Year services will be made by: \_\_\_\_\_ (date)

Student Name: \_\_\_\_\_ IEP DATE: \_\_\_\_\_

### NEED FOR REEVALUATION TO DETERMINE ELIGIBILITY

**IEP NOTES**

Student Name: \_\_\_\_\_

IEP Date: \_\_\_\_\_

Large empty rectangular box for notes.